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FROM: Deanna Laidler
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SUBJECT: Mental Health Parity and Rehabilitative Therapies

A question was recently raised as to whether a coverage guideline contained within the Oregon Health Plan ("OHP") prioritized list complies with mental health parity laws. The coverage guideline at issue limits the number of rehabilitative therapy visits to 30 per year when medically appropriate, with 30 additional visits permitted in exceptional circumstances.

You asked the following specific question on this matter:

Question: In accordance with mental health parity laws, can coverage guidelines for the OHP prioritized list include visit limits on rehabilitative therapy (speech therapy, occupational therapy and physical therapy)?

Short Answer: Yes. According to the Oregon Health Authority ("OHA"), speech therapy, occupational therapy and physical therapy are considered medical/surgical benefits. If this classification of such therapies as medical/surgical benefits is consistent with generally recognized standards of current medical practice, limits on such services will likely be deemed to comply with mental health parity requirements.

Background

I. Mental Health Parity and Medicaid Plans

A. Federal Mental Health Parity Laws

In 1996, Congress passed the Mental Health Parity Act of 1996 ("MHPA"), "which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits" for "employment-related group health plans and health insurance coverage offered in connection with a group health plan."[1] This law did not apply to other kinds of mental health benefit limits, such as visit limits and cost sharing, and it did not cover the treatment of substance use disorders.

In 2008, Congress expanded the mental health parity requirements through The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").[2] The MHPAEA prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical benefits. The MHPAEA requires that mental health and substance abuse benefits be no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification. MHPAEA is not a mandate to require coverage, but rather it is a requirement that when mental health coverage is included in a health plan or policy, the coverage must be in parity with coverage of all other medical conditions.

In 2009, Congress enacted the Children's Health Insurance Program Reauthorization Act, which required Children's Health Insurance Program ("CHIP") state plans that provide both medical and surgical benefits and mental health or substance use disorder benefits to comply with prohibitions on health factor-based discrimination in eligibility and enrollment. In 2010, the Affordable Care Act expanded the provisions of MHPAEA to Medicaid non-managed care benchmark and benchmark-equivalent state plans (also referred to as Alternative Benefit Plans). Such plans were required to include medical/surgical benefits and mental health and substance use disorder benefits and to ensure that the financial requirements and treatment limitations applicable to these benefits comply with the mental health parity provisions.

In 2013, the Departments of Health and Human Services, Labor, and Treasury jointly issued rules implementing the requirements of the MHPAEA and clarifying areas of uncertainty within the statute, including the definitions of "predominant" and "substantially all" when applied to financial requirements and treatment limitations.[3] The rules provide specific guidelines for how health plans should interpret the terms predominant (i.e., more than one-half of the medical/surgical benefits subject to the financial requirements or treatment limitations) and substantially all (i.e., at least two-thirds of the benefits in a classification). The regulations

[1] Pub. L. No. 104-204.
[2] Pub. L. 110-343.
[3] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule, 78 Fed. Reg 68240, 68242 (November 13, 2013)("MHPAEA Final Rules").

identified six broad classifications of benefits, based upon historic plan variances regarding financial requirements and treatment limits by treatment setting (inpatient, outpatient, or emergency setting) and provider network participation (in-network or out-of-network). As written, the MHPAEA final regulations did not apply to Medicaid managed care organizations ("MCOs"), Alternative Benefit Plans ("ABPs"), or CHIP. However, MHPAEA requirements were incorporated by reference into statutory provisions that applied to such entities.

B. Quantitative Limits under Mental Health Parity

MHPAEA generally prohibits issuers that provide mental health or substance use disorder benefits from imposing financial or treatment benefit limitations that are more restrictive than those applied to medical and surgical benefits in the same classification.[4]

Treatment limitations include both qualitative and quantitative treatment restrictions. A quantitative treatment limitation is expressed numerically (e.g., limitations on the frequency of treatment or the number of visits). An insurer may not impose a quantitative treatment limitation on mental health benefits that is more restrictive than the limitation it applies to substantially all (i.e. at least two-thirds) of medical or surgical benefits in the same classification. If a quantitative treatment limitation applies to at least two-thirds of medical benefits in the same classification, it must be no more restrictive than the predominant limitation of that type. The predominant limitation is the level that applies to more than half the medical benefits in the classification. To comply with MHPAEA, an insurer that imposes any quantitative limitation on mental health services coverage would have to impose the same predominant limitation on at least two-thirds of medical and surgical benefits of the same classification. The final rules jointly issued by the Departments of Health and Human Services, Labor, and Treasury has detailed methodologies for the determining treatment limitations and predominant limitations, the "substantially all" test, financial requirements, and the classification of benefits.[5]

C. Mental Health Benefits

Under MHPAEA, the terms ''mental health benefits'' and ''substance use disorder benefits'' mean benefits with respect to services for mental health conditions or substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.[6] The plan terms defining whether the benefits are medical/surgical benefits or mental health or substance use disorder benefits must be consistent with generally recognized standards of current medical practice, as evidenced by relevant professional guidance such as the most current version of the Diagnostic and Statistical Manual of Mental Disorders, the most current version of the International Classification of Diseases, or State guidelines.[7]

[4] 29 USC 1185a.
[5] 45 CFR §146.136(c).
[6] MHPAEA Final Rules, 78 Fed. Reg 68240, 68242.
[7] Id.

D. CMS Guidance on Mental Health Parity

On January 16, 2013, the Centers for Medicare and Medicaid Services ("CMS") issued a letter to State Health Officials clarifying the applicability of MHPAEA provisions to Medicaid plans.[8] In this guidance, CMS adopted the basic framework of MHPAEA and applied the statutory principles as appropriate across these Medicaid and CHIP authorities. As contained within the letter, parity requirements differ somewhat based upon the type of plan and upon wording in the state's CMS approved demonstration projects/waivers.

Alternative Benefit Plans are required to meet the provisions within MHPAEA, regardless of whether services are delivered in managed care or non-managed care arrangements. This requirement extends to ABPs for individuals in the Medicaid expansion group. ABPs cannot include any types of treatment limitations on coverage of mental health or substance use disorder benefits that are more restrictive than those imposed on medical/surgical benefits.

States that enroll children in ABPs are required to assure that eligible children under age 21 receive the full Early and Periodic Screening, Diagnostic and Treatment services ("EPSDT") benefit offered through an ABP or through a combination of an ABP and wrap-around services. States extending Medicaid coverage for children under age 21 through non-managed care ABPs that include the EPSDT benefit will be deemed in compliance with the mental health and substance use disorder parity requirements with respect to the individual. CMS will also deem Medicaid alternative benefit managed care plans to be compliant with MHPAEA, to the extent they provide coverage for children, regardless of whether the MCO provides full EPSDT services or the state assures EPSDT through a wrap-around arrangement.

For CHIP programs, mental health and substance use disorder parity requirements apply to all delivery systems, including fee-for-service and managed care. A state CHP plan will be deemed in compliance with MHPAEA requirements if the plan provides full coverage of the EPSDT benefit. As directed by CMS, states not providing full EPSDT benefits under their CHIP state plan should review the provisions of CHIP state plans, contracts, and CMS-approved waivers to ensure compliance with MHPAEA requirements.

In previous guidance issued in November 2009[9], CMS noted that mental health and substance use disorder parity requirements apply to MCOs that contract with the state to provide both medical/surgical and mental health or substance use disorder benefits. CMS confirmed this in its 2013 State Health Officials letter, and clarified that an MCO would be deemed in compliance with MHPAEA to the extent that the benefits offered by the MCO were consistent with the financial and treatment limitations set forth in the Medicaid state plan and as specified in CMS approved contracts. While CMS does not apply mental health parity requirements to services provided to beneficiaries through a fee-for-service plan, states are encouraged to provide state plan benefits consistent with parity in a way that comports with the mental health parity

[8] CMS, Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans (January 16, 2013), available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[9] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

requirements. CMS also encouraged states to amend their plans and demonstrations/waiver projects to address financial and treatment limitations to further promote parity.

II. Oregon Health Plan

A. Oregon Medicaid Demonstration Project/Waiver

Section 1115 of the Social Security Act (the "Act") gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstration projects is to afford states both flexibility and incentive to design and improve their programs. Under a waiver, state plans are exempt from compliance with specific CMS requirements to the extent such exceptions are specifically included in the waiver approved by CMS.

The OHP has operated under a Section 1115 waiver since 1994, subject to modifications approved by CMS. Most recently, in July 2012, CMS approved an amendment and extension related to Oregon's health system transformation through June 30, 2017. The OHP waiver does not include any provisions specifically exempting plans from compliance with MHPAEA but includes provisions regarding EPSDT services which potentially impact the parity analysis, as further discussed below.

B. Prioritized List

As part of its CMS approved waiver, on a biennial basis, the Oregon Health Evidence Review Commission ("HERC") develops a list of health care services that the Oregon Legislative Assembly, by establishing a funding level on that list, uses to determine coverage under OHP. These services are ranked by priority according to the comparative benefits of each health service. Certain services have corresponding coverage guidelines, which place certain requirements or limitations on the provision of otherwise covered services.

The current OHP prioritized list contains Guideline Note 6, which provides the following limits on rehabilitative therapies:

> A total of 30 visits per year of rehabilitative therapy (physical, occupational and speech therapy, and cardiac and vascular rehabilitation) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year, may be authorized in exceptional circumstances, such as in cases of rapid growth/development.

C. Early and Periodic Screening, Diagnosis, and Treatment

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services ("EPSDT"). EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Act. The EPSDT benefit affords a higher level of services to children than adults, and is designed to provide early

detection and care to children to prevent or timely diagnose and treat health care conditions before they escalate in severity.[10]

EPSDT entitles enrolled infants, children and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.[11]

Services that fit within the scope of coverage under EPSDT must be provided to a child only if necessary to correct or ameliorate the individual child's physical or mental condition. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory requirement.

States may adopt a definition of medical necessity that places tentative limits on services pending an individualized determination by the state, or that limits a treating provider's discretion, as a utilization control, but additional services must be provided if determined to be medically necessary for an individual child. According to CMS EPSDT guidance, "[W]hile a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a "hard" limit could not be applied to children. A state could impose a "soft" limit of a certain number of physical therapy visits annually for children, but if it were to be determined in an individual child's case, upon review, that additional physical therapy services were medically necessary to correct or ameliorate a diagnosed condition, those services would have to be covered."[12]

EPSDT is addressed in the current OHP waiver as follows:

> To allow the state to restrict coverage for treatment services identified during an EPSDT screening for individuals above age 1 to the extent that such services are not consistent with a prioritized list of conditions and treatments. (Applies to all populations, except population 23.)

As approved by CMS, this waiver provision suggests that plans may restrict EPSDT services to the extent such restriction is consistent with limitations contained within the prioritized list. The previous waiver language regarding EPSDT was more detailed and its wording resulted in a different interpretation of the applicability of coverage guidelines to EPSDT:

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[10] CMS, EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents ("CMS EPSDT Guidance"), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

[11] Section 1905(r)(5) of the Social Security Act.

[12] CMS EPSDT Guidance, p. 24.

> The State will inform its provider community that it is exempt only from covering health services below the funding line, and not from any other requirements under the EPSDT program. The State is required to pay for services to treat a condition identified during an EPSDT screening that is within the scope of the benefit package available to the individual. The State must make care available to all individuals under Title XIX if that care would be for treatment of a condition covered on the Prioritized List. The State must arrange for the corrective treatment of conditions identified as part of an EPSDT screening if such conditions are covered on the Prioritized List.

This previous waiver wording extended coverage to all EPSDT services except for services that fell below the funding line. Consistent with the wording of the previous waiver, coverage guidelines that would otherwise impose quantitative limitations on services would not apply to EPSDT services.

CMS Proposed Regulations

On April 10, 2015, CMS issued a proposed rule addressing the application of the MHPAEA to the Medicaid and CHIP programs. While not final, the proposed rule provides insight as to the direction CMS may take with respect to parity and contains numerous recommendations from CMS for state plans to address mental health parity even when not required to do so.

The proposed rule offers a detailed methodology for evaluating financial and treatment limitations applicable to mental health and substance use disorder benefits provided through ABPs to determine whether they are offered at parity with medical/surgical benefits. The proposed methodology is similar to the methodologies in the regulations implementing the MHPAEA for non-governmental plans. The MHPAEA applies directly to benefits offered through CHIP state plans, and the proposed rule describes a similar methodology for determining their compliance with the parity requirement.

The proposed rule would also require states to ensure that Medicaid beneficiaries receiving benefits through a Medicaid MCO have access to benefits that meet the requirements of parity. Previous CMS guidance stated that the plan would not be found in violation if the benefits offered were consistent with limitations established by the state Medicaid agency. The state would be required to document compliance with this rule within 18 months of the effective date of the final rule.

The proposed rule also addresses states that provide mental health benefits and/or substance use disorder benefits through a separate delivery system. At the time a state submits a Medicaid managed care plan contract for review and approval to CMS, the state must provide documentation of how the MHPAEA is met for enrollees of the plan, even if the enrollees receive mental health or substance use disorder benefits through a delivery system other than through the network of the plan.

Discussion

In determining whether the treatment limitations set forth in Guideline Note 6 comply with mental health parity requirements, it must first be determined whether rehabilitative therapies are considered medical/surgical benefits or mental health benefits. As noted above, OHA categorizes speech therapy, occupational therapy and physical therapy as medical/surgical benefits under the OHP. Provided this classification is consistent with generally recognized standards of current medical practice, OHA may include rehabilitative therapies as a medical/surgical benefit given the physical treatment component.

Certain questions arise with respect to the classification for these same therapies when applied to children under age 21 given the interplay between mental health parity and EPSDT benefits are provided to children. According to guidance issued by CMS, states are required to arrange for, and cover for individuals eligible for the EPSDT benefit, any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions, which may include physical therapy and occupational therapy.[13]

While CMS approved OHA's recent waiver which appears to permit the application of treatment limitations for rehabilitative therapies for all Medicaid recipients, OHA may wish to confirm the intent of the waiver wording with CMS.

Please contact me with any follow-up questions that may arise. Pursuant to ORS 180.060(3), persons other than state officers may not rely upon this letter.

Regards,

Deanna
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[13] CMS, Clarification of Medicaid Coverage of Services to Children with Autism (July 7, 2014), available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf